

# PAIN MANAGEMENT



TIMOTHY D. GROTH, MD PC

Dear Patient,

Welcome to our office. We look forward to meeting with you and addressing your pain complaint.

Enclosed you will find a patient questionnaire. It is very important that you take the time to complete this prior to your initial visit. This information will help us understand and treat all aspects of your pain condition. Please bring this information with you at the time of your first visit. In addition, we require that you present a photo I.D. and insurance card to the Registrar upon your arrival.

Due to HIPAA (government) regulations, it is your responsibility to obtain as many records as possible that are available to you. This would include office notes and diagnostic testing (MRI, CT Scan, EMG or X-ray reports). Complete and accurate information will enable us to meet your medical and other needs appropriately. Failure to do so may result in a delay of treatment, as our review of your records are essential in determining the fastest way to relieve your pain.

The last page of this packet is an "Authorization to Obtain Health Information". Please complete and sign the bottom of this form prior to your visit. If in the future you need copies of your records from this office, we require two weeks notice to process. A signed written request must be presented to our office with specific details of the records you are requesting.

Thank you very much for your cooperation. We look forward to meeting you.

Sincerely,

\*\*\*Diagnostic test reports ARE needed at  
time of consult.

Timothy Groth, MD  
Director, Pain Management

**PAIN MANAGEMENT**  
**TIMOTHY D. GROTH, MD PC**  
994 West Jericho Turnpike-Suite 104  
Smithtown, NY 11787  
Phone 631.543.1440 • Fax 631.543.1930

Dear Patient,

As a courtesy, we will bill your insurance carrier directly. Please complete this form and return it to us as soon as possible. If you are insured through a union/local, please send us a completed claim form.

**\*\*CO-PAYMENTS ARE EXPECTED AT THE TIME SERVICES ARE RENDERED\*\***

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

INSURANCE INFORMATION

Primary Ins:	Secondary Ins:
Company: _____	Company: _____
Address: _____	Address: _____
Phone #: _____	Phone #: _____
Insured's Name: _____	Insured's Name: _____
ID #: _____	ID #: _____
Group #: _____	Group #: _____
Place of Employment: _____	Place of Employment: _____
Work Phone #: _____	Work Phone #: _____

WORKER'S COMPENSATION/ NO FAULT INFORMATION (If Applicable)

Do you have a no fault insurance?  Yes  No      Date of Accident: \_\_\_\_\_

Do you have workers comp insurance?  Yes  No      Date of Accident: \_\_\_\_\_

Insurance carrier: \_\_\_\_\_

Address: \_\_\_\_\_

Claim #: \_\_\_\_\_      WCB #: \_\_\_\_\_

Employer: \_\_\_\_\_      Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Your cooperation in this matter is greatly appreciated**

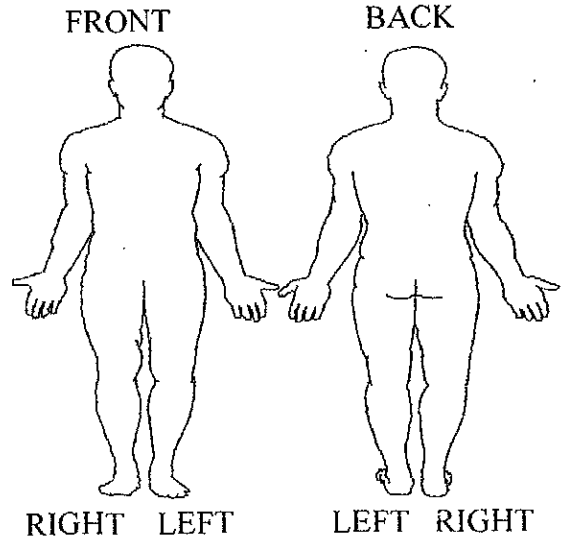
Name: \_\_\_\_\_

Date: \_\_\_\_\_

**INITIAL CONSULT**  
**Where Is Your Pain Now?**

Please use the appropriate symbols to describe your symptoms and mark the location as accurately as possible on the body drawing.

- ACHING            ^ ^ ^ ^ ^
- STABBING        // // // // //
- TINGLING        \_\_\_\_\_
- BURNING         XXXXX
- NUMBNESS       0000000



**HOW BAD IS YOUR PAIN NOW?**

(NO PAIN ) 1 2 3 4 5 6 7 8 9 10 (WORST)

**Who is referring you to our practice?** \_\_\_\_\_

**List current PAIN medications:**

\_\_\_\_\_

**List all PAST PAIN medications** you have tried at any point for your current pain complaints:

\_\_\_\_\_

**Please list ALL medications** you are currently taking (dosage and frequency):

_____	_____
_____	_____
_____	_____
_____	_____

**Are you currently taking any blood thinners or anti-coagulants?**     YES     NO

**If YES, which ones?**     Aspirin     Plavix     Coumadin     Eliquis     Pradaxa  
 Xeralto     Effient     Lovenox     Other \_\_\_\_\_

**Have you tried any of the following for treatment of your current pain complaints?**

- Spine Surgery             Physical Therapy             Chiropractic Therapy
- Accupuncture             Massage Therapy             TENS unit

**Mark the following physicians you have consulted for your current pain complaints?**

Orthopedic Surgeon     Neurosurgeon     Neurologist     Rheumatologist     Other \_\_\_\_\_

**Please list the names of any other Pain Physicians you have seen in the past?**



PATIENT QUESTIONNAIRE

Today Date: \_\_\_/\_\_\_/\_\_\_

Your Information:

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_-\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Race (circle one): African-America/ Asian/ Caucasian/ Hispanic/ Native American

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Describe your pain:

Date problem started: \_\_\_/\_\_\_/\_\_\_

Is this injury from a motor vehicle accident? \_\_\_\_\_

Is this injury from a work related accident? \_\_\_\_\_

Are you employed? \_\_\_\_\_

Describe your injury:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Which hand is dominant? Left Right

Do you experience any weakness? Left - Arm/ Leg Right - Arm/Leg

Do you experience numbness/tingling? Left - Arm/ Leg Right - Arm/Leg

Does pain interrupt your sleep? YES NO

Has pain changed your normal activities?

Sleeping \_\_\_\_\_ Dressing \_\_\_\_\_ Enjoyment of life \_\_\_\_\_  
Walking \_\_\_\_\_ Hobbies \_\_\_\_\_ Exercising \_\_\_\_\_  
Eating \_\_\_\_\_ Relationships \_\_\_\_\_ Mood \_\_\_\_\_  
Sports \_\_\_\_\_ Work/housework \_\_\_\_\_ Other \_\_\_\_\_



# PAIN MANAGEMENT



**TIMOTHY D. GROTH, MD PC**  
Authorization to Obtain Health Information

Doctor, Hospital Facility: _____
Address: _____
Patient Name: _____
Address: _____
Phone Number: _____ Date of Birth: _____

I authorize you to disclose health information of the above named individual to:

**Timothy D. Groth, MD PC**  
**994 West Jericho Turnpike**  
**Suite 104**  
**Smithtown, NY 11787**

Please select from below any information you would like to be sent to Dr. Groth to aid in your diagnosis and treatment. Please provide dates of service where it applies.

- |   |  |
|---|--|
| <input type="checkbox"/> Operative Report       | <input type="checkbox"/> Consultation Reports from ___ to ___      |
| <input type="checkbox"/> Anesthesia Record      | <input type="checkbox"/> Medication Sheets                         |
| <input type="checkbox"/> Discharge Instructions | <input type="checkbox"/> Physicians Progress Notes from ___ to ___ |
| <input type="checkbox"/> Discharge Summary      | <input type="checkbox"/> Physicians Orders from ___ to ___         |
| <input type="checkbox"/> EKG                    | <input type="checkbox"/> X-rays, MRI from ___ to ___               |
| <input type="checkbox"/> History and Physical   | <input type="checkbox"/> Entire medical record                     |
| <input type="checkbox"/> Laboratory Results     | <input type="checkbox"/> Other: Specify _____                      |

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV), behavioral or mental health services, and treatment for alcohol and drug abuse. For AIDS and HIV status, the department of Health Authorization must be completed instead of this authorization.

I understand that I have a right to revoke this authorization at anytime; I must do so in writing and present my written revocation to Medical records. Unless revoked, this authorization will expire on the following date, event or condition.

(You may indicate "none" if you wish to indicate a specific date)

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain copies of the information to be used or disclosed, as provided in the applicable Federal and State law. If I have questions about the disclosure of my health information, I can contact the medical records department.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Timothy D. Groth, MD. PC.  
Pain Management  
994 W. Jericho Turnpike Suite 104  
Smithtown, NY 11787

## NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_ understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information will be use to:

- \*\*Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
- \*\*Obtain payment from third party payers.
- \*\* Conduct normal healthcare operations such as quality assessments and Physician certifications.

I understand that I may request in writing that Dr. Groth's office restrict how my private information is to be used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Dr. Groth's office is not required to agree to my requested restrictions, but are bound to abide by such restrictions to them.

List below any friend or family member(s) you give the authority to pick up information concerning your treatment if you are unable to come to the office.

I have read and/ or received a copy of the HIPPA Notice of Privacy Practice.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



# PAIN MANAGEMENT AGREEMENT

TIMOTHY D. GROTH, MD  
PETER A. KECHEJIAN, MD  
GULLE N. AWAN, DO

Please initial each item:

\_\_\_ I will not request any controlled substance or medications or prescriptions from another physician or practice while I am receiving such medications from Dr. Groth, Dr. Kechejian, and Dr. Awan unless discussed with Dr. Groth, Dr. Kechejian, and Dr. Awan previously. You must notify this office if additional medications are prescribed by another healthcare provider (e.g., a hospital or an emergency room).

\_\_\_ Refill prescriptions for controlled maintenance medications will be re-written every 30 days. It is your responsibility to schedule a monthly office visit. Be sure to make your appointment AT LEAST 2 weeks in advance.

\_\_\_ A single pharmacy will provide the medication. At the beginning of this agreement you must designate the name of that pharmacy. The name and address of the pharmacy are as follows:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_ Lost medications or pain medication prescriptions will not be replaced.

\_\_\_ You will be subject to urine testing upon request, which will test for the presence of any drugs in your system.

\_\_\_ Any breach of agreement will result in permanent discharge from the practice.

\_\_\_ I understand that my medication may make me drowsy and that my reflexes and reactions may be slowed. I agree that such things like operating heavy machinery or equipment, a motor vehicle or working in unprotected conditions may result in harming others or myself. I understand I must be responsible for my actions while taking any controlled substances.

\_\_\_ I AGREE NOT TO DRINK ANY ALCOHOL BEVERAGES WHILE I AM TAKING MEDICATIONS PRESCRIBED BY THIS OFFICE.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## NOTICE OF DISCLOSURE OF OWNERSHIP INTEREST

Corporations, including local physicians own the North Shore Surgi- Center and Suffolk Surgery Center, one of whom is Timothy D. Groth, MD. These physicians have become owners as a result of their commitment to quality healthcare and service to their patients.

The North shore Surgi-Center and Suffolk Surgery Center may have a financial relationship with your physician as indicated above. You have the right to choose where to receive services, including and entity in which your physician may have a financial relationship.

St. Catherine of Siena Medical Center  
50 Route 25A  
Smithtown, NY 11787  
(631) 862-3000

Peconic Bay Medical Center  
1300 Roanoke Ave.  
Riverhead, NY 11901  
(631) 548-6000

PLEASE INITIAL HERE \_\_\_\_\_

### PAIN MANAGEMENT RISKS AND COMPLICATIONS

CORTISONE INJECTIONS may have the following side effects: increased appetite, facial flushing, fluid retention, feeling your heart racing and feeling energized. Frequent repetitive cortisone injections can increase bone loss and contribute to osteoporosis. There fore, we recommend that you take Calcium and Vitamin D.

INTERVENTIONAL PAIN MANAGEMENT injections are safe and have a long track record with complications occurring rarely. However, the complication rate is not 0%. The most common complication is a post dural puncture headache (Spinal Headache), which occurs in the approximately 1% of cases.

EXTREMELY RARE COMPLICATIONS including bleeding, infection or adverse reaction to medication, which can result in death, paralysis, loss of bowel or bladder control, increased pain or weakness or the need to emergency surgery.

I have been informed of he risk of developing tolerance, or an addiction to opioids, and also of the risk of addiction to any newborn children of female patients taking opioids while pregnant.

I give permission of the prescribing physician to contact my pharmacy directly, at the physician's discretion, to review and evaluate data. My signature below grants permission to release such requested information.

I, \_\_\_\_\_, understand all of the above and will comply.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT INFORMED CONSENT FOR OPIOID TREATMENT FORM

### PATIENT INFORMED CONSENT FOR OPIOID TREATMENT FORM

Patient Name \_\_\_\_\_

WCB Claim # \_\_\_\_\_

Doctor Name \_\_\_\_\_

I plan to take a pain medicine called OPIOIDS. This pain medicine may help improve my pain but it may also cause some serious problems. The problems may be worse if I mix the pain medicine with alcohol or other drugs.

I understand that the pain medicine I will be taking may cause serious problems including:

- ⇒ Confusion.
- ⇒ Poor judgment.
- ⇒ Nausea (a stomach ache).
- ⇒ Vomiting.
- ⇒ Constipation (hard stools that may be painful to push out).
- ⇒ Sleepy or drowsy feeling.
- ⇒ Poor coordination and balance (such as feeling unsteady, tripping, and falling).
- ⇒ Slow reaction time.
- ⇒ Slow breathing or I can stop breathing - which could cause me to die.
- ⇒ More depression (such as feeling sad, hopeless, or unable to do anything).
- ⇒ Dry mouth.
- ⇒ Increased feeling of pain (hyperalgesia).
- ⇒ Addiction (it may be very hard to stop taking the pain medicine when I'm ready to quit).
- ⇒ For men: the pain medicine may lead to less interest in sex and poor sexual performance.
- ⇒ For pregnant women, the pain medicine may hurt my unborn child and may cause my child to be born addicted to the pain medicine.

I will tell my doctor if I have any of the problems listed here.

I understand there may be other problems caused by the pain medicine, in addition to the problems listed here.

I understand that these problems may get better when I stop taking the pain medicine.

My doctor has reviewed the serious problems that this pain medicine may cause. My doctor has answered all questions that I have about this pain medicine and the serious problems it may cause.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*I attest that this form was reviewed by me with the patient and all questions were answered.*

Doctor Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## PATIENT UNDERSTANDING FOR OPIOID TREATMENT FORM

PATIENT UNDERSTANDING FOR OPIOID TREATMENT FORM	
Patient Name _____	WCB Claim #: _____
Doctor Name _____	
I am taking a pain medicine called OPIOIDS to help improve my pain.	
I agree (the patient must initial each box to show agreement):	
<input type="checkbox"/> I will take my pain medicine exactly the way my doctor tells me to. That means I will take the right amount of pain medicine at the right time.  <input type="checkbox"/> I will tell my doctor about any new medical problems.  <input type="checkbox"/> I will tell my doctor about all medicine I take, and will tell my doctor if I am given any new medicines.  <input type="checkbox"/> I will tell my doctor if I see another doctor, or if I go to the Emergency Room.  <input type="checkbox"/> I will only get my pain medicine prescription from this doctor. My doctor's name is listed on the top of this page.  <input type="checkbox"/> If my doctor is away, I will only get medicine from the doctor who is in charge while my doctor is away.  <input type="checkbox"/> I will only get my pain medicine from one pharmacy (drug store).  <input type="checkbox"/> I will follow my doctor's directions about therapy, exercises and physical things to do so I can learn to live with my pain.  <input type="checkbox"/> I will do what I can to get back to work.  <input type="checkbox"/> I will not drink alcohol or use any other drugs unless I am told to do it by my doctor.	<input type="checkbox"/> When I am asked, I will get lab tests to see if I am taking my medicines the right way.  <input type="checkbox"/> If the lab tests show that I am not taking the medicines the way I should, my doctor may cut down or stop my medicine or send me to a specialist or special program to help care for me.  <input type="checkbox"/> I will store my pain medicine in a safe place where other people cannot take it.  <input type="checkbox"/> I will keep my scheduled appointments. If I must miss an appointment, I will call my doctor to cancel at least 24 hours before the appointment.  <input type="checkbox"/> My doctor may stop giving me pain medicine if: <ul style="list-style-type: none"> <li>• I do not follow this agreement.</li> <li>• The pain medicine is not helping me.</li> <li>• I'm not meeting my goals in active therapy.</li> <li>• My pain or my functions do not improve.</li> <li>• I have bad side effects from the pain medicine.</li> <li>• I become addicted to the pain medicine.</li> <li>• I give or sell the pain medicine to someone else.</li> </ul> <input type="checkbox"/> I am not pregnant and I will call my doctor as soon as possible if I think I may be pregnant.
Patient Signature: _____	Date: _____
<i>I attest that this form was reviewed by me with the patient and all questions were answered.</i>	